Connecticut Community KidCare: A Plan to Reform the Delivery and Financing of Children's Behavioral Health Services

Executive Summary

A Report to the General Assembly

Pursuant to June Special Session Public Act 00-2, Section 5

From the Connecticut Department of Children and Families and Department of Social Services

Presented by

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to Reform the Delivery and Financing of Children's Behavioral Health Services

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Submitted by:

Department of Social Services and Department of Children and Families

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PREFACE

This report was prepared by the Children's Behavioral Health Implementation Team, an interdepartmental work group formed by the Departments of Social Services and

Children and Families working in close collaboration with the Office of Policy and Management and the Child Health and Development Institute of Connecticut, Inc.[1] The Institute retained F. Carl Valentine and Associates and Holt, Wexler & Farnam, LLP to assist in the preparation of the analyses and the report. The report was informed by discussions with the Children's Behavioral Health Advisory Committee[2] and reflects comments on the August 2000 Request for Information. Special thanks are extended to the Connecticut Health Foundation and the Children's Fund of Connecticut, both of which contributed funding to support system planning and preparation of this report. Thanks are also extended to Morgan Meltz, parent, Karl Kemper, DCF Regional Administrator, and Karen Snyder, DMHAS Assistant Commissioner for their thoughtful review and design contributions.

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Executive Summary

Introduction

The Department of Children and Families (DCF) and Department of Social Services (DSS) are preparing to embark on a sweeping reform of the public child behavioral health service system. The new Connecticut Community KidCare initiative is designed to eliminate the major system gaps and barriers that have plagued child behavioral health in recent years. The proposed initiative will allow children with behavioral health problems to grow and develop within nurturing family environments, increasing their ability to succeed in their homes, schools and communities. The new system will be family driven and family focused, giving families choice and helping families to care for children who have behavioral health challenges. The new system will emphasize the strengths of individual families and children and be culturally responsive.

Connecticut Community KidCare
Key Features

- Comprehensive behavioral health program with flexible benefit package including treatment and "wraparound" support services
- Full carve-out of HUSKY child behavioral health
- Community-based and culturally competent care planning and service delivery
- Greatly expanded community-based service capacity
- Families involved and supported in decision making role with strengthened family advocacy organizations
- Comprehensive training for all agency and system staff and parents
- Efficient balance of local control of care with statewide administrative support structure
- Integrated funding to support broad benefit package
- Reinvestment of increased Medicaid reimbursements
- Routine performance reports on key outcomes and quality measures

♂ Better mechanisms for coordination of care.

♂ Enhanced community-based resources and treatment alternatives.

♂ Integrated funding.

♂ Family involvement in policy as well as service planning for their own children.

♂ Redistribution of resources and refinancing of the service system.

The report recommended that Connecticut move to a *system of care* approach to children's mental health services, building on the emerging network of 22 Community Collaboratives (formerly referred to as Local Systems of Care, LSOCs or SOCs) around the state. The system of care approach will actively involve families in service planning and create the opportunity for flexibility in service planning so that children with a serious emotional disturbance are better able to live in their homes and communities.

The proposed reforms were supported by the June Special Session Public Act 00-2, Sections 3-5, in which the General Assembly endorsed the direction of the report and its call for the restructuring of children's behavioral health service delivery and financing. The Governor's Blue Ribbon Commission on Mental Health also expressed strong

support for this initiative in its final report, which called for similar reforms in the adult public mental health system.

This plan is submitted in response to the requirements of June 2000 Special Session Public Act 00-2, Sections 3-5, in which the General Assembly charged the Commissioners with developing the elements of a plan to reform the current system. This report summarizes the planning and development activities that have taken place since the February 2000 report, and outlines the system's anticipated structure and organization. The framework outlined in this report is based on feedback obtained when DCF and DSS issued a Request for Information (RFI) in August of 2000. The RFI sought input about how to reform the children's behavioral health system, and as a result of this feedback, this report now reflects the input of families, providers, and other members of the community who participated on key advisory committees and responded to requests for public comment.

The plan represents a paradigm shift that introduces Lead Service Agencies (LSA) that have overall responsibility for managing behavioral health services for enrolled children within a designated catchment area. The Lead Services Agencies will work with local service providers and local Community Collaboratives to provide quality behavioral health and support services for all enrolled children. The LSAs will be assisted by a statewide Administrative Service Organization (ASO) with responsibility for managing integrated funding streams and for basic administrative services such as claims processing, contract management, data management and reporting. Children with complex behavioral health service needs will have unprecedented support made possible by integrated funding. Care coordinators will partner with families to create comprehensive, coordinated Individual Service Plans, so that these children are better able to live at home and go to school in their communities.

The Governor's commitment to this program and a Medicaid revenue maximization effort to help finance the work has already been demonstrated by his direction to expand child behavioral health services and supports in the community. Within the next six months, DCF will procure and begin funding in-state specialized residential services and selected community-based services including short-term crisis stabilization, mobile emergency psychiatric services, care coordination services, outpatient psychiatric coverage, extended day treatment, intensive home-based services, and specialized mentoring. This sizable investment will facilitate the return of children from residential treatment facilities and HUSKY subacute programs, as well as the diversion of children who are being considered for residential care.

DSS, DCF and OPM have made great strides in designing the program's organizational structure and financing. Aspects of this design will continue to evolve during the planning process based on input from families, providers, legislators, advocates, and other interested stakeholders. The State welcomes input from all interested readers of this report to help build a better program.

Overview of Reform

Connecticut Community KidCare ("KidCare") is based on a system of care model in which service planning is driven by the needs and preferences of the child and family. The reform involves an expansion and redistribution of funds for children's behavioral health services that will place greater emphasis on preventing children's problems from escalating by providing a wider array of culturally competent services delivered in the home or in the community. The reform also will support the development and financing of an independent family-run organization to provide family-to-family support and encourage active family participation in treatment and system planning.

These reforms will result in a significant reduction in length of stay in psychiatric hospitals and residential treatment placements as well as a reduction in out-of-community and out-of-state placements.

Eligibility

The February 2000 Report recommended a partial carve-out of children's behavioral health services. Under this initial model, only those HUSKY enrolled children in the child welfare system and those with special behavioral health needs would be enrolled in KidCare. Nearly every respondent to the August 2000 RFI expressed a strong preference for a full carve-out model, in which all of the HUSKY child behavioral health services currently provided by the HUSKY plans would instead be provided as part of KidCare. The Departments have decided to move forward with a full carve-out. This decision is supported by a preliminary analysis of HUSKY encounter data, which indicated that children enrolled under a partial carve-out would account for more than 95% of child behavioral health expenditures; a pattern consistent with similar programs in other States. A partial carve out would leave few funds for the current HUSKY Managed Care Organizations (MCOs) to provide less intensive but necessary behavioral health services for the children who remained in their charge. The MCOs would have little incentive to prevent the deterioration of mild behavioral disorders or to invest in prevention and early intervention programs that might reduce the number of children with intensive needs. Thus, all children enrolled in the HUSKY A and B plans will be enrolled in KidCare for their behavioral health needs. The HUSKY plans will continue to be responsible only for *primary* behavioral health care[3] and behavioral health pharmacy services.

Children who are not HUSKY eligible may be able to enroll in KidCare through the DCF Voluntary Services Program. The Voluntary Services Program is not an entitlement and thus access to KidCare through Voluntary Services will be regulated by DCF based on resource availability. It is anticipated that the application process will be handled by the LSAs, and that the Administrative Services Organization will determine eligibility according to DCF policy. The Voluntary Services Program criteria are based primarily on a child's symptoms and functional status. These criteria will be reviewed and may be subject to change.

Benefit Package

The centerpiece of KidCare is a comprehensive benefit package made possible by the integrated management of DSS and DCF funding streams including Medicaid (Title XIX), State Children's Health Insurance Program (SCHIP or Title XXI), Title IV-E (board and care), and State general funds. The comprehensive benefit includes a full complement of *behavioral health treatment services* such as outpatient treatment, day program, home-based, and care coordination services, as well as out-of-home services such as residential center treatment, therapeutic foster care, and hospitalization. The benefit package also includes a range of *non-medical support services*, such as respite care and therapeutic recreation, which are often essential to allow children with behavioral health challenges to live in their homes and communities.

Family Involvement

Families will play an instrumental role in ensuring that each aspect of the system is accountable and responsive to the behavioral health needs of children and their families. DCF is supporting the development of a Family Support Organization to assure that children with serious behavioral health needs and their families have voice, access, and ownership in the development and implementation of their service plans. Families will have opportunities for involvement at multiple levels, from local family advocacy to input into policy and planning. Family involvement will help make Community KidCare responsive to families and accountable to communities. Childcare, transportation, and flexibility in meeting times, will help make it possible for families to participate. DCF and DSS are committed to financing this involvement, and ensuring that all aspects of culture are addressed as part of this initiative.

Organizational Structure

DCF and DSS will administer KidCare under an interagency agreement (also referred to as a memorandum of understanding). The agreement sets forth a pre-implementation process, so that both Departments are involved in building the management infrastructure and developing the policies, procedures, contracts, and standards necessary to support DCF's administration of the program. Post-implementation, DCF will have primary responsibility for management of the KidCare program. DSS will monitor program compliance with Medicaid and SCHIP requirements.

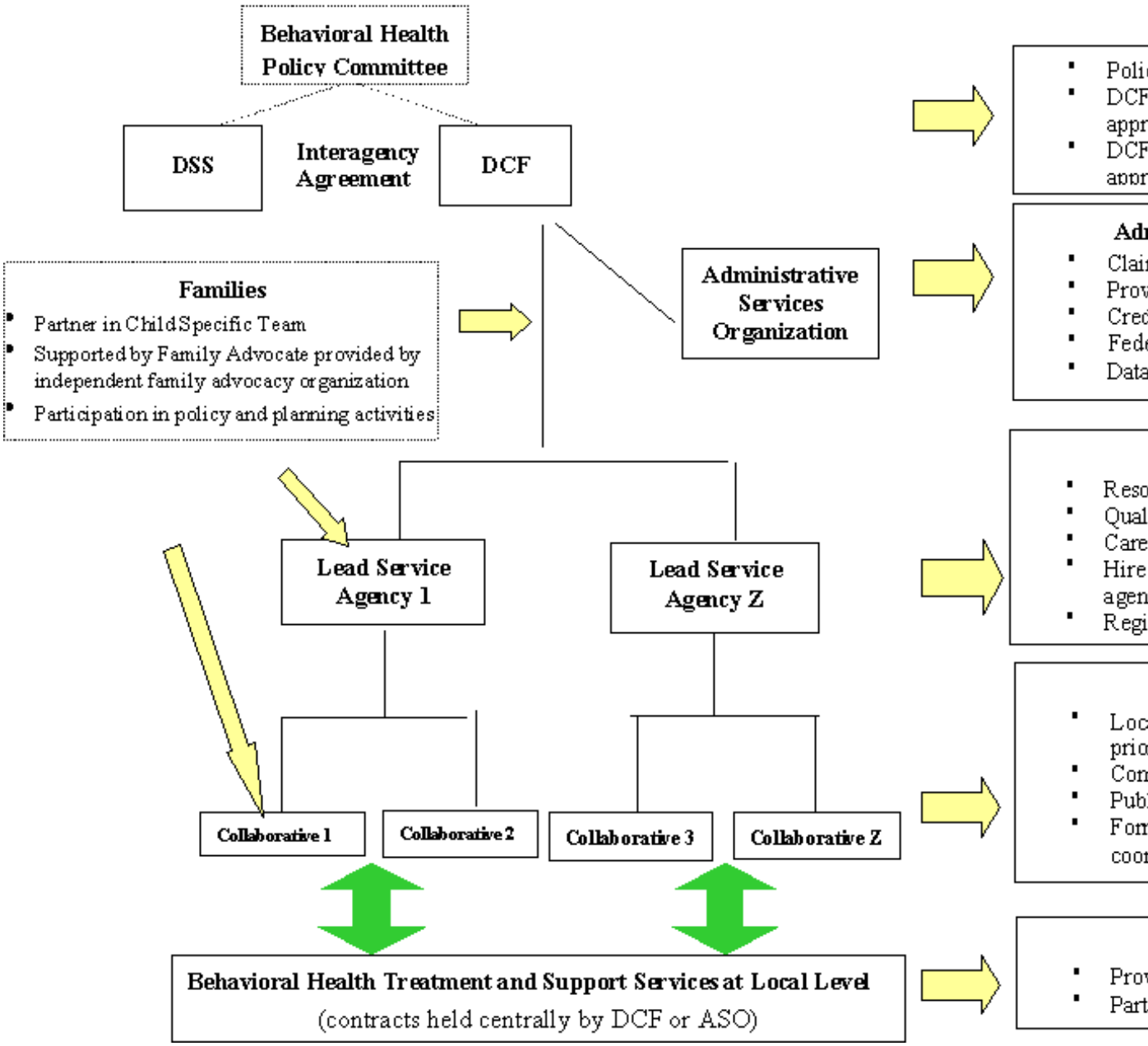
The new administrative structure (see Figure 1) will include an Administrative Service Organization (ASO), Lead Service Agencies (LSAs), and Community Collaboratives. DCF will procure and contract with an ASO to assume responsibility for claims payments, reporting, contracting, and other functions that are best conducted centrally.

The DCF regional offices will in turn contract with LSAs selected under a competitive procurement process. A minimum of five, but no more than twelve LSAs will be selected; the final number will be determined by a variety of factors including the number and qualifications of respondents to the RFP and financial analyses of service and administrative dollars available to finance the system. The LSAs will assume responsibility for managing the care of all enrolled children residing within their

designated catchment areas. LSAs will have authority to manage service utilization and will have responsibility for local quality management and for overseeing the development of local community resources.

The LSAs will be responsible for ensuring that *all* enrolled children have access to quality behavioral health services, and they will have special responsibility for the care of children with complex behavioral health service needs. Children with *complex service needs* require the coordinated involvement of multiple state agencies (e.g., DCF, State Department of Education, Department of Mental Retardation, Court Services, and, for older children, Department of Mental Health and Addiction Services). In addition to specialized treatment and educational services, families of these children often require non-medical support services such as respite and mentoring and the support of friends, relatives, neighbors, churches, supports groups, and other community organizations.

Figure 1: Organizational Framework for Connecticut Community KidCare



The LSAs will employ *care coordinators* to work with families of children with complex service needs. The care coordinators will partner with families and children to design flexible, Individual Service Plans. Although LSAs are accountable for the care provided by care coordinators, most of the care coordinators will be based at provider agencies located throughout the LSA's catchment area. Thus, most of the care coordination will be carried out within local Community Collaboratives. A Community Collaborative is a local consortium of providers, parents and service agencies that have organized to develop coordinated, comprehensive community resources for children with complex

service needs and their families. The Collaboratives may be small or large, encompassing from one to twenty cities and towns. Members of the Collaboratives have close working relationships and intimate knowledge of local needs and resources and thus are in the best position to work with families to create child and family specific teams and design Individual Service Plans.

Grievance and Appeals

DCF will assume responsibility for managing the KidCare grievance and administrative hearings procedures. All parents of children enrolled in KidCare will have the right to timely procedures for resolving complaints, concerns, and appeals, otherwise referred to as grievances. These procedures will meet all State and Federal grievance requirements (i.e., Federal Medicaid and Title IV-E requirements), and will be presented in writing and described to children and their parent/custodian at the time of enrollment. The grievance process will be available to resolve disagreements related to the denial, reduction, suspension, or termination of services, or the failure to respond in a timely way to a request for services.

Quality Management

DCF will assume overall responsibility for quality management, although quality management activities will take place at multiple levels within the KidCare program. Quality management will focus on sentinel event review (i.e., specific events that may cause concern) and system wide quality improvement. DCF will develop performance measures against which the State and LSAs can assess the effectiveness of the behavioral health care system. This will address widespread concerns about whether system investments result in positive outcomes for children. This system will also allow State agencies to meet program and fiscal reporting requirements to maintain and enhance federal funding.

Performance measures will be identified in the areas of finance, administration, clinical process, and outcome. These data will be collected on a statewide basis using uniform data elements, data definitions, data fields and timing in order to facilitate performance comparisons. The ASO will have primary responsibility for data collection and for assuring that key stakeholders (e.g., DSS, DCF, LSAs, Collaboratives, advisory committees, and members of the community) have timely, reliable, accurate, and informative reports that are useful for managing the system.

Training and Staff Development

No matter how innovative system reform efforts are, their effectiveness in improving outcomes for children and families is ultimately limited by the quality and competency of the managers and direct service delivery personnel who provide services on a daily basis. Changing practice will require ongoing mentoring, supervision, and support, and the periodic learning of new skills. To assist in creating a comprehensive approach to developing a system of training that supports the implementation of KidCare, DCF has

contracted with the Child Health and Development Institute of Connecticut, Inc. (CHDI) to design a training plan and develop curriculum. CHDI is partnering with the Human Service Collaborative (HSC), of Washington, D.C. to assist in this effort. The partners of HSC bring a wealth of experience in the field of children's behavioral health and have provided training and technical assistance nationwide in the design, development, and implementation of systems of care for children with behavioral health problems. This consulting group is working with a core team in Connecticut that includes State and regional State agency staff, family advocates, community agency providers, and representatives from the Yale Child Study Center and the Department of Psychiatry at the University of Connecticut School of Medicine.

The purpose of the training will be to create and implement competency-based curricula to improve the knowledge, skills and attitudes of front-line, supervisory, and management staff from DCF, and staff in the service agencies with whom DCF contracts. The curricula will address the implementation requirements of KidCare and best service practices for the care of children with, or at risk of, serious emotional disturbances and their families. In addition, training opportunities will be developed for staff in other child-serving systems including schools and the judiciary, as well as family advocates.

Evaluation

An evaluation will be conducted to provide information about the services being delivered, how the services are being utilized and by whom, the extent to which services are effective, and the costs of the service system. The evaluation will also encourage accountability, cost consciousness, and responsiveness to those in need of and using services. DCF has contracted with CHDI to assist in the design and development of the evaluation. CHDI has secured matching grants from the Children's Fund of Connecticut and the Connecticut Health Foundation to help support the work during this fiscal year. DCF will seek additional State and private funds for the full-scale evaluation for future years. DCF, CHDI, and DSS have convened an evaluation workgroup responsible for the development of evaluation goals and methods and the procurement of an independent evaluator.

Financing

The integration of State and Federal funding streams will be necessary to support the proposed comprehensive benefit package. This will require changes in legislation and the re-appropriation of some dollars currently appropriated to DSS. It is anticipated that all or a portion of the following funding streams will be used to establish the integrated funding pool:

· The behavioral health portion of the capitation rate for the HUSKY Part A (Title XIX) and Part B (Title XXI) Managed Care Organizations,

· HUSKY Plus Behavioral funds,

· A portion of State funds currently used for reinsurance in Part A of the HUSKY program, redirected to community-based services,

· Title IV-E and State general fund dollars used for residential treatment, group care, and therapeutic foster care for children with behavioral health problems,

· Other DCF State and Federal funds spent on children's behavioral health services,

· Revenues derived from ASO billing of responsible third party payers.

Fee for service Medicaid funds for Medicaid-eligible children will not be included in the funding for Community KidCare. The anticipated flow of funds under KidCare is illustrated in Figure 2.

The State anticipates that there will be additional federal Medicaid revenue from Medicaid revenue maximization strategies resulting from claims for residential and community-based treatment. A small working group consisting of a consultant under contract to CHDI and staff from DCF, DSS, and the Department of Administrative Services (DAS) have been working since the spring of 2000 to develop and implement a system for maximizing Medicaid reimbursement for DCF placements in residential facilities, and to enhance reimbursement for community-based care.

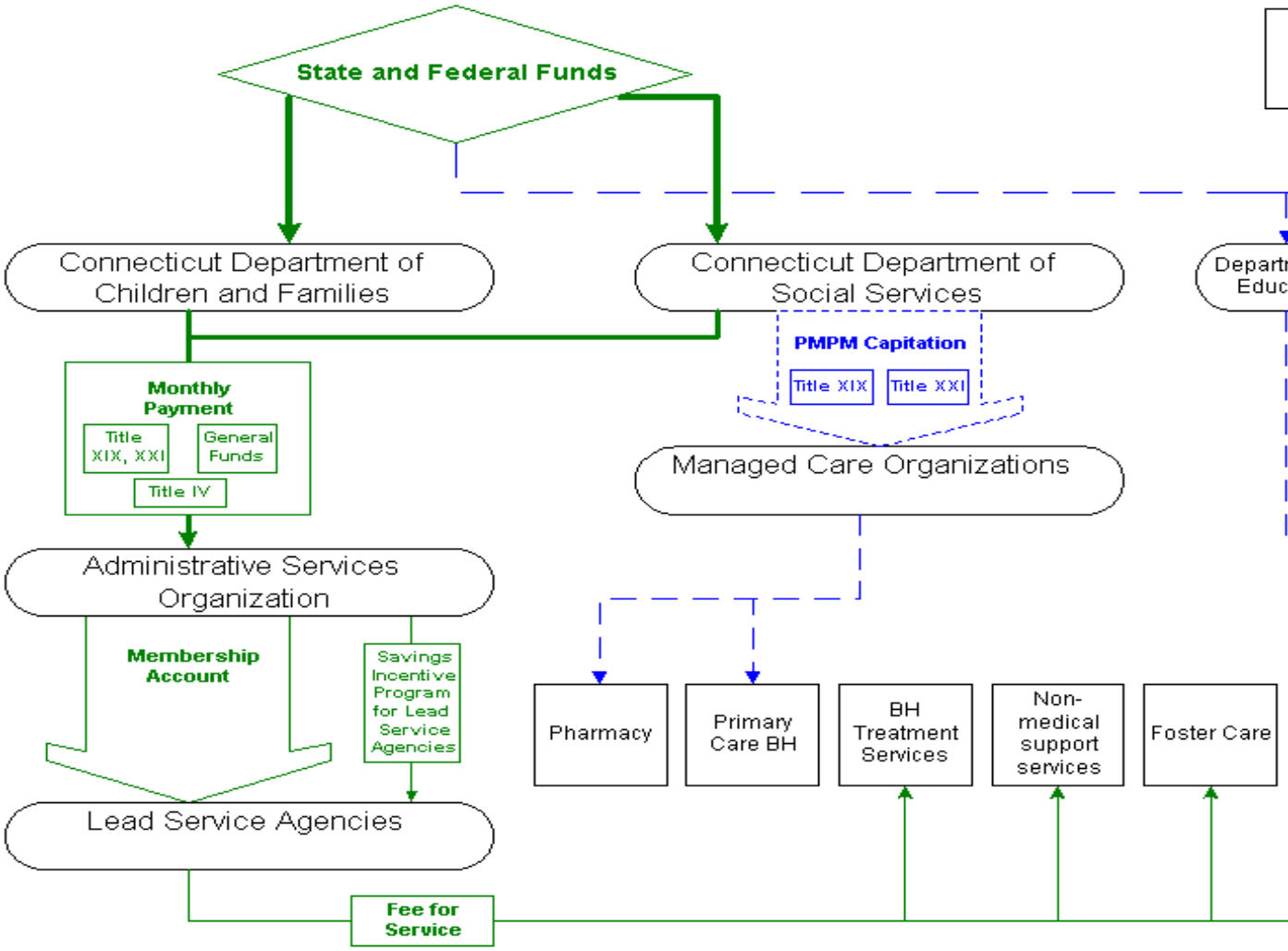
Implementation

The implementation of this reform is best conceptualized as an incremental process, one that requires the development of additional management and administrative capacity within the Departments as well as service infrastructure and human resource development at the local level. The Departments have established July 1, 2002 as the target date by which the new system will begin to be phased-in. The groundwork that needs to be laid for phase-in is considerable including financial analysis and budgeting, HUSKY B legislative changes, a new federal waiver or waiver amendment (section 1915b), and LSA/ASO procurement and contracting.

Pre-implementation (January 1, 2001-June 30, 2002). Preparation for phase-in will be conducted over the next 18 months. During this period DCF and DSS will be engaged in efforts to improve service delivery and address some of the system's most pressing problems. DCF will introduce a range of new and expanded services, including services that will be part of the comprehensive benefit available under Community KidCare. Special services such as care coordination, family advocacy, and emergency mobile psychiatric services will be greatly enhanced to better meet the needs of children with complex behavioral health service needs. Changes in practice will also be supported by the implementation of the Community KidCare training plan. The independent evaluation team will be selected and have the opportunity to design the evaluation and collect baseline data.

DSS will implement changes in the HUSKY A program that will improve MCO/DCF collaboration in the care of children with serious behavioral health disorders, and encourage support for comprehensive and coordinated outpatient service plans. These changes include modifying contract incentives to support increased community based care.

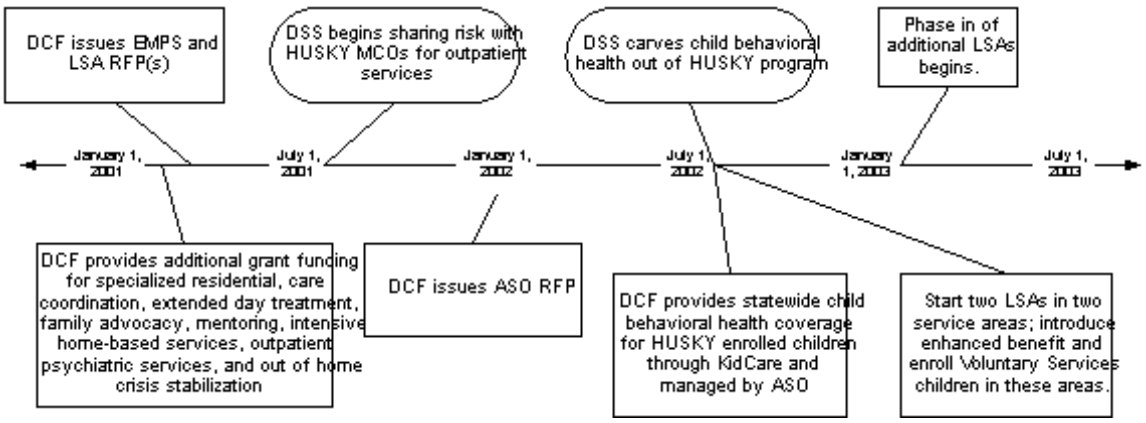
Figure 2: Flow of Funds



Implementation (July 1, 2002). Under the current proposal, the phase-in would begin with DCF procuring and contracting with an ASO to administer a full carve-out of the HUSKY child behavioral health benefit, beginning July 1, 2002 (see Figure 3). Shortly thereafter, LSAs would be brought on-line in two catchment areas. An *enhanced* benefit including non-medical support services (e.g., respite, mentoring) would be introduced in these catchment areas. The LSAs would assume responsibility for managing the full KidCare benefit package, which would include the HUSKY benefits and the enhanced benefits. Additional LSAs would be brought on in a sequential manner until the entire

program is in operation statewide. It is expected that the phase-in will be complete in 1 to 2 years.

Figure 2: Implementation Timeline



Concluding Comment

The Departments of Children and Families and Social Services have charted a course for unprecedented system reform and have committed to an enduring partnership. The plan outlined in this document provides a vision for the future-a vision in which children and families have access to behavioral health services and a choice of providers-a vision that celebrates family, community and culture-a vision that embraces prevention and early intervention-a vision that provides flexibility and responsiveness. Connecticut can improve the lives of children and families, and Community KidCare is the way.

1 The Institute is a not-for-profit organization established by the Children's Fund of Connecticut to promote and maximize the healthy physical, behavioral, emotional, cognitive and social development of children throughout Connecticut. The Institute creates, supports, and facilitates innovative primary and preventive strategies for children, and works to maximize the effectiveness of the institutions and systems that contribute to their well being.

2 The Children's Behavioral Health Advisory Committee was established in 1999 to provide input into the February 2000 report to the legislature and subsequent work on design of the reforms recommended therein.

3 Primary behavioral health care includes all behavioral health services provided by primary care providers.